

as if "fixation" had not been produced. Another important object is to effect complete and permanent adhesion of a sufficient area of the anterior surface of the uterus to the abdominal wall. The ideal ventrifixation is that which results from Cæsarean section when the wound is longitudinal, involving about the middle third of the uterus, and extensive and complete and symmetrical adhesion takes place between the uterine and abdominal wounds. In these cases when pregnancy occurs again, as I have known it to do repeatedly, there are absolutely no abnormal symptoms, either functional or mechanical, resulting from the adhesion, and the operation may be repeated almost or altogether without opening the peritoneum. I have only once had occasion to open the abdomen in a patient who had undergone ventrifixation in the manner which I am advocating, and I took the opportunity of examining the relations of the uterus to the abdominal wall. The uterus appeared to be completely incorporated with the anterior parietes in its middle third, and yet the patient had never experienced any unpleasant symptom referable to the uterus or bladder during the several years that had elapsed since the operation. If this can be true in one case why not in all? We cannot avoid adhesions of bowel or omentum after an intra-abdominal operation producing a wound; we should therefore try to make the adhesions strong, regular, and useful instead of leaving them for chance to make them weak, irregular, and dangerous. Firm and broad attachment is not in itself troublesome or dangerous. The *a priori* objection to firm and permanent adhesion is opposed to all the lessons of experience.

THE OPERATION.

The following description is given by the author of the operation advocated by him.

In performing the operation of ventrifixation I have discarded all suture material except catgut and the finest silk thread which can be conveniently manipulated. At first I used to try to close completely the vesico-uterine fold but now for several years I have introduced only two sutures, one at each side, well below the lowest point of the abdominal wound. This is quite sufficient practically to close the fold without interfering with the distension of the bladder, and it is, therefore, a preventive to any possible insinuation of intestine. The next step is to suture the peritoneum near the edge of the wound at each side. The fine silk sutures are introduced from the outside surface of the peritoneum, passed through the peritoneum, and after taking a good hold of

the uterus low down and near its margin they are brought back through the peritoneum and firmly tied. The knot is thus always extra-peritoneal. Two or three such sutures are, as a rule, introduced on each side. The same process is now continued with this addition, that the next sutures include the fascia as well as the peritoneum on each side. The transverse sutures are next introduced. These are two or three in number; they consist of fine silk and include fascia and peritoneum at the sides, and each takes a fairly extensive hold of the anterior surface of the uterus. The highest of the sutures is placed less than half-way up from the isthmus to the fundus. In complicated cases, and when the prospect of pregnancy is very remote, the sutures have been placed occasionally a little higher. All the sutures that penetrate to any part of the uterine tissue are buried sutures at the finish. The abdominal wound is closed in the usual way, and it is an advantage to suture separately the edges of the fascia with fine silk. The last step in every case is the introduction of a glycerine pad pessary into the vagina to press forward and support the uterus as a splint during the formation of adhesions. The patients are kept in bed for about a month.

Some Practical Makeshifts in Nursing.

(Concluded from page 284.)

Where rapid sterilisation of dressings is necessary, and no oven available, a very hot flat-iron is useful, especially at midwifery cases. A flat-iron also may be used for hastily warming a bed where no other means are at hand. In lieu of a hot-water bottle, a workman's enamelled-iron tea bottle, securely corked, will be found satisfactory. That, too, is supplied by the village shop.

An inhaler can be formed by inverting an enamelled-iron funnel in a cup of the same material, which has a slightly larger diameter than the funnel; or a small enamelled basin may be used instead of a cup. This can be placed on a spirit lamp or oil stove and reheated when required. An ordinary wide-based kettle, with a straight spout, may easily be converted into a bronchitis kettle with the aid of a yard of medium copper or galvanised wire, obtainable for less than a penny from any ironmonger, and a length of wide rubber tubing. Pass the wire down the spout into the kettle until it touches the bottom. Over that slip the tubing, stretching it over the mouth of the spout, or, if this be too wide,

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